United States Court of Appeals

for the Second Circuit

APPELLEE'S BRIEF AND APPENDIX

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P/S

IN THE

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

Docket No. 74-2358

MARSHALL W. CLARK, JR.,

Appellant

v.

CASPAR WEINBERGER, SECRETARY
OF THE UNITED STATES DEPARTMENT
OF HEALTH, EDUCATION & WELFARE,

Appellee

Appeal from the United States District
Court for the District of Vermont

BRIEF AND APPENDIX OF APPELLEE

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2

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TABLE OF CONTENTS

TABLE OF CASES

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BRIEF FOR THE APPELLEE

Preliminary Statement

Marshall W. Clark, Jr., appeals from a memorandum and order of the Honorable James S. Holden, Chief United States District Judge, entered July 26, 1974 in the United States District Court for the District of Vermont affirming an order of the Secretary of the United States Department of Health, Education & Welfare which denied Clark disability insurance benefits after a full hearing by an administrative law judge and a review by the Appeals Council which also received additional evidence.

STATEMENT OF FACTS*

Marshall W. Clark, Jr., an unemployed 38 year old male, sought review in the District Court, pursuant to 42 U.S.C. §405(g), of a final decision of the Secretary denying him disability insurance benefits under the Social Security Act. A prior application for disability benefits was denied after hearing in 1969. The present application was made on September 8, 1970. After denial of the present application, a hearing was requested and granted. The hearing was conducted by an administrative law judge in Burlington, Vermont on October 17, 1971. Counsel was present to represent the plaintiff. The administrative law judge found "that the medical evidence of record fails to establish that up to June 30, 1971 the claimant's epileptic impairment was so severe that he was prevented thereby from engaging in any substantial gainful activity." June 30, 1971 was the last date the special

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*The facts set forth herein are a summary of the facts upon which the District Court based its decision. A more complete statement may be found in Defendant's Memorandum in Support of Motion for Summary Judgment set forth in the appendix hereto.

earnings requirement was met. This decision was affirmed by the Appeals Council on June 25, 1973, after consideration of additional evidence submitted by the plaintiff.

The principal impairment, which the plaintiff contends rendered him disabled prior to the date when he last met the special earnings requirement, was a recurrent seizure disorder, diagnosed as grand mal epilepsy. The medical evidence introduced at the hearing included reports and statements from various hospitals and physicians, as well as the plaintiff's own description and those of his wife. The administrative law judge also considered exhibits from the prior hearing conducted in 1969.

According to the medical evidence, the plaintiff was admitted to the neurology clinic of the U.V.M. Medical Center with complaints about headaches and nausea in November 1968. An electrocardiogram and an electroencephalogram were normal. Radiograms of the skull showed no abnormality. Repeat brain scans were within normal limits. The plaintiff again visited the Medical Center on June 23, 1970, after being transferred there from the Kerbs Memorial Hospital emergency room for evaluation. He had passed out that morning and was taken by ambulance to Kerbs. An electroencephalogram report was normal. All Neurological examinations were again within normal limits.

The plaintiff had also been consulting Dr. Robert Engisch since the mid-sixties. Doctor Engisch indicated in reports to the administrative law judge that the plaintiff had been having grand mal seizures since 1966 and that one such seizure had been witnesses at the Kerbs Hospital in August of 1972. Doctor Engisch indicated that the plaintiff was "disabled to a certain extent only" - that he could perform any non-dangerous occupation which would not require operation of a motor vehicle or dangerous machinery; otherwise, he was employable. Dr. W. Dale Hooper of St. Albans, Vermont, who had also treated the plaintiff, indicated in a letter to the plaintiff's attorney on June 14, 1971, that the plaintiff had grand mal epilepsy which precluded him from engaging in gainful employment.

Other testimony introduced at the hearing included descriptions by the plaintiff's wife of his seizures and she testified that at that time he was having three or four a month. Also a letter of the plaintiff's aunt was considered, which described the seizures she had witnessed. The decision of the administrative law judge considered the fact that the plaintiff was receiving disability benefits from the Veterans Administration and the State of Vermont and that his driver's license had been

suspended due to his physical condition. The plaintiff's last employment was with Vermont Industrial Homeworks in 1970. There was also medical evidence that if the claimant took prescribed medication as directed, his epileptic condition would be better controlled.

ARGUMENT

I. BOTH THE DISTRICT COURT AND THE ADMINISTRATIVE LAW JUDGE APPLIED THE PROPER LEGAL TEST OF DISABILITY.

Plaintiff argues that the District Court erred in its finding that the Administrative Law Judge applied the proper test of disability. The argument is without merit and misreads the District Court's Memorandum and Order.*

First, plaintiff argues (Plaintiff's Brief, p. 4 - 5), citing a Fifth Circuit case, DePaepe v. Richardson, 464 F.2d 92 (5th Cir. 1972), that there are four elements of proof that a claimant is "unable to engage in any substantial gainful activity" and is thus under a "disability" as defined by Section 216 (42 U.S.C. §416 (i)(1)) of the Social Security Act, and that the Administrative Law Judge and the District Court failed to consider one or more of these elements. This argument is simply not supported by the record. The claim that

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*The Memorandum and Order may be found in the Appendix to this brief.

medical evidence (meaning expert evidence) was considered to the exclusion of lay evidence is unfounded and based on a selective reading of the record. The Administrative Law Judge specifically considered both lay and medical evidence when measuring the plaintiff's claimed disability against the proper regulations and found, "The lay and medical evidence, summarized above, does not show that any of the foregoing exists, so far, in this case." (Administrative Record, p. 39) (emphasis added).

Similarly, the District Court also considered all elements of proof adduced at the hearing and which were part of the record. In fact, the District Court defines the medical evidence not simply as expert evidence but to include "reports and statements from various hospitals and physicians, as well as the plaintiff's own descriptions and those of his wife." (Opinion, p. 2).

The claim that epileptic impairment was considered to the exclusion of other medical problems is also not supported by the record. The Administrative Law Judge considered the claims of blindness and deafness (Administrative Record, p. 37) but found that "The claimant assigned recurrent epileptic seizures as the reason for his stated inability to engage in substantial gainful

activity. (Administrative Record, p. 38). Similarly, the District Court stated:

> The principal impairment, which the plaintiff contends rendered him disabled prior to the date when he last met the special earnings requirement, was a recurrent seizure disorder diagnosed as grand mal epilepsy.

(Opinion, p. 2).

Indeed, in his application for disability benefits, plaintiff listed no disability other than "seizures". (Administrative Record, p. 113). Nevertheless, the Administrative Law Judge conscientiously considered the other minor ailments revealed by the lay and medical evidence.

Thus, the claim that the improper legal tests were used is not supported by the record.

II. THE DISTRICT COURT PROPERLY FOUND THAT THE ADMINISTRATIVE LAW JUDGE'S FINDINGS AND DECISION WERE BASED ON SUBSTANTIAL EVIDENCE.

Plaintiff contends that the Administrative Law Judge placed greater reliance on some evidence than he did on other evidence. (Plaintiff's Brief, pp. 10, 13). It is, of course, the function and duty of the Administrative Law Judge to weigh the evidence and resolve conflicts in the evidence and on the record. Ragan v. Finch, 435 F.2d 239 (6th Cir. 1971); Miller v. Finch, 430 F.2d 239 (8th Cir. 1970).

The District Court properly found that an individual claiming a disability within the meaning of 42 U.S.C. §416(i)(1) has the burden of proving such a disability. The plaintiff was also called upon to establish that he was disabled prior to June 30, 1971, the date he last met the special earnings requirement. The disability must be total and to the extent that the claimant is precluded from engaging in any substantial gainful activity. Floyd v. Finch, 441 F.2d 73 (6th Cir. 1971). The fact that the plaintiff is receiving disability benefits from the V.A. and the state is not controlling on the Secretary; it is only one factor to be

considered along with other evidence presented. Martin v. Ribicoff, 196 F. Supp. 547 (D.C. Mont. 1961).

It was the duty of the hearing judge to evaluate the medical evidence on the central issue of the claimant's ability to engage in any gainful employment. In weighing the medical evidence on the effect of the claimant's epilepsy, it was within his province to attach greater significance to the opinion of the neurologist than the differing view of a doctor who had not specialized in this field.

CONCLUSION

The decision of the District Court upholding the findings of the Administrative Law Judge should be affirmed by this Court.

Respectfully submitted,

GEORGE W. F. COOK
United States Attorney

By: William B. Gray
WILLIAM B. GRAY
Assistant U. S. Attorney

January 3, 1975

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

Marshall W. Clark, Jr

v.

Casper Weinburger,
Secretary of the United States
Department of Health,
Education and Welfare

Civil Action

File No. 73-235

MEMORANDUM AND ORDER

The plaintiff, an unemployed 38 year old male, seeks review in this court, pursuant to 42 U.S.C. § 405(g), of a final decision of the Secretary denying him disability insurance benefits under the Social Security Act. A prior application for disability benefits was denied after hearing in 1969. The present application was made on September 8, 1970. After denial of the present application, a hearing was requested and granted. The hearing was conducted by an administrative law judge in Burlington, Vermont on October 17, 1971. Counsel was present to represent the plaintiff. The administrative law judge found "that the medical evidence of record fails to establish that up to June 30, 1971 the claimant's epileptic impairment was so severe that he was prevented thereby from engaging in any substantial gainful activity." June 30, 1971 was the last date the special earnings requirement was met. This decision was affirmed by the Appeals Council on June 25, 1973, after consideration of additional evidence submitted by the plaintiff.

In order to qualify for the claimed benefits the plaintiff must show a disability as defined by the Social Security Act. Section 216 (42 U.S.C. § 416(i)(1) of the act defines disability as "The inability to engage in any substantial gainful activity

by reason of any medically determinable physical or medical impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months."

The findings of an administrative agency are conclusive if supported by substantial evidence. Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Consolidated Edison v. NLRB, 305 U.S. 197, 229 (1938). To determine whether the findings are supported by substantial evidence the reviewing court is required, under § 706 of the Administrative Procedure Act, to examine the whole record; evidence detracting from the weight of the findings must be taken into account as well. Universal Camera Corp. v. NLRB, 340 U.S. 474, 487 (1951); Gold v. Secretary of Health, Education and Welfare, 463 F.2d 38 (2d Cir. 1972); Dolan v. Celebreeze, 381 F.2d 231 (2d Cir. 1967).

The principal impairment, which the plaintiff contends rendered him disabled prior to the date when he last met the special earnings requirement, was a recurrent seizure disorder, diagnosed as grand mal epilepsy. The medical evidence introduced at the hearing included reports and statements from various hospitals and physicians, as well as the plaintiff's own descriptions and those of his wife. The administrative law judge also considered exhibits from the prior hearing conducted in 1969.

According to the medical evidence, the plaintiff was admitted to the neurology clinic of the U.V.M. Medical Center with complaints about headaches and nausea in November 1968. An electrocardiogram and an electroencephalogram were normal. Radiograms of the skull showed no abnormality. Repeat brain scans were within normal limits. The plaintiff again visited

the Medical Center on June 23, 1970, after being transferred there from the Kerbs Memorial Hospital emergency room for evaluation. He had passed out that morning and was taken by ambulance to Kerbs. An electroencephalogram report was normal. All neurological examinations were again within normal limits.

The plaintiff had also been consulting Dr. Robert Engisch since the mid-sixties. Dr. Engisch indicated in reports to the administrative law judge that the plaintiff had been having grand mal seizures since 1966 and that one such seizure had been witnessed at the Kerbs Hospital in August of 1972. Dr. Engisch indicated that the plaintiff was "disabled to a certain extent only" - that he could perform any non-dangerous occupation which would not require operation of a motor vehicle or dangerous machinery; otherwise, he was employable. Dr. W. Dale Hooper of St. Albans, Vermont, who had also treated the plaintiff, indicated in a letter to the plaintiff's attorney on June 14, 1971, that the plaintiff had grand mal epilepsy which precluded him from engaging in gainful employment.

Other testimony introduced at the hearing included descriptions by the plaintiff's wife of his seizures and she testified that at that time he was having three or four a month. Also a letter of the plaintiff's aunt was considered, which described the seizures she had witnessed. The decision of the administrative law judge considered the fact that the plaintiff was receiving disability benefits from the Veterans Administration and the State of Vermont and that his driver's license had been suspended due to his physical condition. The plaintiff's last employment was with Vermont Industrial Homeworks in 1970. There was also medical evidence that if the claimant took prescribed medication as directed, his epileptic condition would be better controlled.

An individual claiming a disability within the meaning of 42 U.S.C. § 416(i)(1) has the burden of proving such a disability. It is within the province of the Secretary to weigh all the evidence and to resolve any conflicts in the evidence and on the record. Ragan v. Finch, 435 F.2d 239 (6th Cir. 1971); Miller v. Finch, 430 F.2d 239 (8th Cir. 1970). The plaintiff was also called upon to establish that he was disabled prior to June 30, 1971, the date he last met the special earnings requirement. The disability must be total and to the extent that the claimant is precluded from engaging in any substantial gainful activity. Floyd v. Finch, 441 F.2d 73 (6th Cir. 1971). The fact that the plaintiff is receiving disability benefits from the V.A. and the state is not controlling on the Secretary; it is only one factor to be considered along with other evidence presented. Martin v. Ribicoff, 196 F.Supp. 547 (D.C.Mont. 1961).

It was the duty of the hearing judge to evaluate the medical evidence on the central issue of the claimant's ability to engage in any gainful employment. In weighing the medical evidence on the effect of the claimant's epilepsy, it was within his province to attach greater significance to the opinion of the neurologist than the differing view of a doctor who had not specialized in this field.

Review of the full record makes it clear that the decision of the hearing judge is founded on substantial evidence. Accordingly, the order of the Secretary is affirmed.

Dated at Rutland, in the District of Vermont, this 26th day of July, 1974.

James S. Holden
Chief Judge

UNITED STATES DISTRICT COURT

FOR THE

DISTRICT OF VERMONT

MARSHALL W. CLARK, JR. Plaintiff v. CASPAR W. WEINBERGER, Secretary of Health, Education, and Welfare Defendant	)	CIVIL ACTION NO. 73-235

DEFENDANT'S MEMORANDUM IN SUPPORT

OF MOTION FOR SUMMARY JUDGMENT

Statement of the Case

This is an action under section 205(g) of the Social Security Act, as amended, 42 U.S.C. 405(g), to review a "final decision" of the Secretary of Health, Education, and Welfare. This section provides, inter alia, that "The court shall have power to enter,upon the pleadings and transcript of the record, a judgment affirming, modifying or reversing the decision of the Secretary, with or without remanding the case for a rehearing" and that "The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive." Section 205(h) of the Act, 42 U.S.C. 405(h), expressly restricts the judicial remedy to the aforesaid manner of judicial review and contains a prohibition against an action under the general jurisdiction of the Federal district courts for a money judgment.

Administrative Proceedings

On September 8, 1970 plaintiff made application 1/ for the establishment of a period of disability and for disability insurance benefits, alleging that he became unable to work on September 15, 1966, at age 30 (Tr. 113-116). He last qualified for insured status on June 30, 1971 (Tr. 33, 117, 121). The application was denied initially (Tr. 117-118) and again on reconsideration (Tr. 120) by the Social Security Administration. The administrative law judge

1/ Plaintiff filed a prior application on February 16, 1968 which was denied initially and on reconsideration (Tr. 92), by an administrative law judge (Tr. 95-103), and by the Appeals Council (Tr. 112). Because plaintiff did not continue to prosecute his right to further timely appeal, the prior application is not before the Court for review at this time.

before whom plaintiff appeared with his attorney and witness, considered the case de novo, and on November 22, 1972, found that plaintiff was not under a disability on or before June 30, 1971 when he last met the requisite disability insured status (Tr. 31-41). The Appeals Council approved the administrative law judge's decision on June 25, 1973 (Tr. 4-5), rendering it the "final decision" of the Secretary of Health, Education, and Welfare, subject to judicial review.

Statement of the Issue

The issue for determination is whether there is substantial evidence in the record to support the decision of the Secretary that plaintiff (having the burden of proof thereof) failed to establish that he was under a disability within the meaning of the Social Security Act by June 30, 1971, the last day on which he had an insured status under the Act for disability purposes.

Applicable Statutory Provisions

The Social Security Act defines disability both in Sections 216(i)(1) and 223(d)(1) (42 U.S.C. 416(i)(1) and 423(d)(1)) as the:

> *... inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months.*

Section 223(d) (42 U.S.C. 423(d)) further provides in pertinent part that:

> *(2)(A) ... an individual ... shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.*
>
> * * * * *
>
> *(3) ... a "physical or mental impairment" is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.*
>
> * * * * *

(5) An individual shall not be considered under a disability unless he furnishes such medical and other evidence of the existence thereof as the Secretary may require.

Statement of Facts

When he filed his application in September 1970, plaintiff alleged that he had become unable to work on September 15, 1966 because of seizures (Tr. 113). He last met the insured status requirement for disability purposes on June 30, 1971 (Tr. 121). Plaintiff alleges that he cannot raise his arms to shave, because they get numb and his hands get shaky (Tr. 123). He also alleges he has bronchial asthma, which with his impaired vision and hearing combine to make him nervous and uncertain (Tr. 123).

Copies of medical records furnished by the Medical Center Hospital of Vermont at Burlington, Vermont indicated that plaintiff was admitted to that facility on May 31, 1965, with a chief complaint of pain in the left knee (Tr. 128-131). Additional records furnished by the same hospital indicate that plaintiff was admitted to the neurology clinic on November 6, 1968, with a chief complaint of headache for the last 3 months (Tr. 132-134). At that time plaintiff recited a history of having had a headache on the right side of the head for about 3 months, increased during the last few days. He had increased nausea and vomiting together with being dizzy, and he had fallen down during one of these spells. He also had what seemed to be random movements of the hands and feet following vomiting. The laboratory data were unremarkable, and an electroencephalogram showed a normal record. An X-ray of the chest showed some generalized increased interstitial markings that were not pronounced, but were more than would be expected in a young man. Radiographs of the skull showed no abnormality of the cranial vault. A brain scan was interpreted as being within normal limits, but because of some question of the results a repeat brain scan was done and this again was within normal limits. An EKG was normal. Audiometry revealed occupational deafness in both ears. His visual fields were full. Plaintiff tolerated the diagnostic procedures well, and was relatively comfortable in the hospital with the exception of one episode of a severe headache without visual or auditory symptoms. He had progressive vomiting with relief in about 5 minutes. Plaintiff was discharged

on November 13, 1968, with the following diagnoses: 1. Migraine headache; 2. Decreased visual acuity of the left eye of undetermined etiology; 3. Occupational deafness in both ears; and 4. Status post left knee surgery (Tr. 132-134).

The next medical records furnished by the Medical Center Hospital consisted of an emergency room clinical record dated June 23, 1970 (Tr. 136-137). Plaintiff had been transferred there from Kerbs Memorial Hospital emergency room for evaluation. He had a seizure that morning with amnesia for events. He had an abrasion and a contusion around the left eye. An examination of the cranial nerves from I to XI showed that they were intact. His deep tendon reflexes were equal bilaterally, and there was no motor paralysis. A laceration at his right elbow was sutured. Chest X-rays taken on July 21, 1969, showed no change in the appearance of the chest since the examination of November 7, 1968. The cardiac silhouette was within normal limits. There was slight accentuation of the pulmonary markings but no evidence of any active infiltrate was seen. Some changes were seen which probably represented an inactive process (Tr. 136-137). Additional records furnished by the hospital showed that skull X-rays taken on June 23, 1970, were negative for bony abnormalities (Tr. 139-142). When plaintiff was seen on August 14, 1970, he gave a history of a seizure disorder, usually one a day, for the past 3 years. An electroencephalogram taken that day was within normal limits. He indicated that he wished to go to the Veterans Administration Hospital in order to establish a service related injury as the basis for his seizure disorder (Tr. 139-142).

Further records were furnished by the Department of Neurology, Ambulatory Care Facility, DeGoesbriand Unit, Medical Center Hospital of Vermont (Tr. 155-157). These records indicate that plaintiff is a poor historian, and a partially disabled veteran who apparently has had a questionable seizure disorder for the past 3 years. He admitted to having had 8 to 10 seizures per day up until approximately 6 months ago. Since that time he has had about one a month. These seizures consist of loss of consciousness at which time he falls to the ground, and he has been told that he shakes all over with occasional loss of control of his bowels or urine. He has also been told that he has bitten his tongue on occasion and has injured himself many times. These seizures are usually precipitated by some emotional upset. He claims to be taking his medication faithfully every day. The objective findings

are all negative or within normal limits. The clinical impression is that he has a seizure disorder in fair control. Plaintiff was also complaining of frequent headaches, usually right-sided, severe, throbbing, associated with nausea and vomiting, at times vomiting blood. However, the neurologic examination was within normal limits. Despite plaintiff's vehemence that he had been taking his medication, blood levels drawn on his last visit showed a Dilantin level of 0.6 mgs. percent and a Phenobarbital level of 0.9 mgs. percent, which is not therapeutic. When plaintiff was confronted with this information he stated that possibly he might miss an occasional dose of his medication. It was believed that plaintiff was addicted to Talwin. It was recommended that he discontinue taking this medication. When he was seen on September 1, 1971, the clinical impression was that he had a questionable seizure disorder in good control. Plaintiff had stopped taking his Talwin and he had not noticed any increased frequency in his headaches. The neurologic examination was again within normal limits. The clinical impression was that he was having vascular headaches (Tr. 155-157).

Medical records furnished by the Kerbs Memorial Hospital Outpatient Department indicate that plaintiff was brought to that facility by ambulance on June 23, 1970 (Tr. 138). He had become upset by a family problem that morning and he allegedly lost consciousness. By 3:30 p.m. he was found to be alert and oriented, but he had complete amnesia for all events that afternoon. His pupils were equal and they reacted to light. There was no peripheral paralysis. He was complaining of a headache. There was an abrasion on the left side of his forehead, and a contusion around the left orbit. He had 3 superficial lacerations, each less than 1/2 inch in size, an abrasion of the right elbow, and a superficial abrasion of the back. His abrasions were cleansed and dressed. He was given a shot of tetanus toxoid and transferred to the Mary Fletcher Unit for further evaluation (Tr. 138). A medical note written on the stationery of the Kerbs Memorial Hospital and addressed to the Vermont Legal Aid Office on March 27, 1973, indicates that Dr. Engisch can certify that plaintiff had seizures as early as 1966 (Tr. 186-187). He had a negative EEG, which is usual 50 percent of the time, in 1966. His grand mal seizures were under control with Dilantin 500 mg. q.i.d., and Phenobarbital 60 mg. twice a day. The control is said to be good on this medication (Tr. 186-187).

Robert R. Engisch, M.D., who is listed as a neurologist on the staff of the Medical Center Hospital at Burlington, Vermont 2/ completed a medical report

2/ American Medical Directory, 24th Edition, 1967.

for the Department of Social Welfare on November 20, 1968, in which he indicated that plaintiff had experienced headaches for the past 3 months, and that there had been a question of a seizure disorder for the past 6 months (Tr. 160-161). Plaintiff also had poor vision in the left eye, probably since childhood. There was also occupational deafness which had existed for over 10 years, and residuals of a left knee injury and surgery on the cartilage by a Dr. Rust. On November 6, 1968, x-rays of the skull were within normal limits, and laboratory study results were also normal. On November 7, and November 8, 1968, an EEG and brain scan were within normal limits (Tr. 160-161). Dr. Engisch completed another medical report for the Department of Social Welfare on March 3, 1969 in which he indicated that the diagnoses were: 1. Migraine headache; 2. Possible seizures; 3. Decreased visual acuity of the left eye; 4. Occupational deafness; 5. Status post left knee operation with limp; and 6. Mild situation reaction. The prognosis with regard to diagnoses numbers one and two was said to be good, with regard to number six excellent, and with regard to three, four and five, static (Tr. 166-168).

On June 20, 1969, Dr. Engisch again completed a medical report which listed essentially the same diagnoses (Tr. 172-173). In this report Dr. Engisch indicated that there was no limitation of walking, standing, stooping, kneeling, lifting, reaching, pushing and pulling. Plaintiff was able to work outside or inside under all climatic conditions (Tr. 172-173). This physician wrote two letters to the administrative law judge in June 1969 in which he indicated that his purpose for writing was to let the administrative law judge know that plaintiff was on medications and was being seen regularly (Tr. 108, 109). The physician also wanted to emphasize that he did not think that plaintiff was unemployable because of seizures. He seemed to criticize the practices of employers which worked to the detriment of persons with seizure disorders. Dr. Engisch stated that he encouraged his patients, with seizures, to lead totally normal lives outside the legal restrictions placed upon them, usually by State motor vehicle authorities because of recurring episodes (Tr. 108-109). The evidence contains a copy of a letter written by Dr. Engisch to plaintiff's attorney on October 23, 1972 (Tr. 178). This letter was intended to corroborate their recent conversation about plaintiff. According to this letter plaintiff

has had seizures for some time, and he has been a patient of this physician since the mid-1960's. Plaintiff was actually witnessed while he was having a major seizure in the OPC area at Kerbs Hospital in early August (Tr. 178). On October 11, 1972, another letter was written by Dr. Engisch indicating that plaintiff's seizures were modestly controlled, and that he was moderately reliable in keeping appointments (Tr. 179). Plaintiff was also seen because of abdominal discomfort which had suggested evidence of a gastritis. Because of his seizures, plaintiff was disabled to a certain extent only; he could not drive a motor vehicle and was unable to operate dangerous machinery. Plaintiff also had to avoid heights. For these reasons he would be unemployable in occupations with these needs. If properly qualified, he could work at any non-dangerous occupation. The gastritis would have no effect on his employ-ability (Tr. 179). Another letter addressed to plaintiff's attorney by Dr. Engisch on April 30, 1973, indicates that plaintiff had seizures since at least 1966 (Tr. 185). This physician observed one of these seizures at the Kerbs Hospital and treated it in the emergency room. Plaintiff's seizures were both major and fragmentary in nature. Plaintiff has not had a positive EEG, but this of course was not unusual because about half of the patients with frank seizure disorders, especially of the nature and fragmentary (not petit mal , not temporal type), have normal EEG's. Dr. Engisch indicated that he was not able to comment on the frequency of the seizures. Plaintiff appeared to take his medication regularly. The physician was aware of plaintiff's having several a month, but the precise number was not clear. These were said to occur during the day and not during sleep (Tr. 185).

W. Dale Hooper, M.D., a surgeon (Tr. 152), submitted a medical report which indicated that plaintiff's seizures frequently had been precipitated by, or preceded, an acute emotional disturbance either in the form of excitement or anger (Tr. 143-148). Since July 1970 he had been taking Compazine 5 mgm. b.i.d. which had controlled his emotional instability to some extent and decreased the number of seizures. The status of plaintiff's seizures was being evaluated at Neurology Service, DeGoesbriand Memorial Unit, Medical Center Hospital of Vermont, where plaintiff had electroencephalogram studies performed about 4 weeks ago.

This physician concluded that plaintiff had grand mal epilepsy (Tr. 143-148). In a letter dated June 13, 1971, addressed to plaintiff's attorney, Dr. Hooper indicated that it was his opinion from observing plaintiff for the past 19 months that he was totally disabled for any type of gainful employment on the basis of his emotional instability which was apparently producing grand mal seizures (Tr. 153-154).

A copy of a medical record submitted by a Veterans Administration Center indicates that plaintiff's examination was essentially within normal limits, including neurological examination (Tr. 149). Plaintiff cooperated poorly on sensation testing, but he appeared to be intact. He refused to stay, and was discharged against medical advice on the same day that he was admitted (Tr. 149).

George G. Lucchina, M.D., an internist[3/] completed a medical report for the Department of Social Welfare on December 22, 1967, at which time plaintiff complained chiefly about his left knee which he had injured in 1958 (Tr. 162-164). In 1964 the swelling of the knee was still evident. A Dr. Rust advised and performed surgery on the knee. Since that time plaintiff had no more pain, but had instability on occasions ranging from every six months to a few weeks. This was somewhat disabling to him in that he was accident prone. This physician's diagnoses were: 1. Aseptic osteochondritis of the left knee by history and X-ray; 2. Lumbar disc syndrome with lumbar instability; and 3. Congenital blindness in the left eye (Tr. 162-164).

Robert E. Goodwin, O.D., furnished a medical report on October 16, 1972 indicating that plaintiff was being fitted with spectacles in order to furnish protection by means of hard resin lenses, as he has an amblyopic left eye (Tr. 177). The correction of his hyperopia in the ambylopic left eye produced improved visual acuity, and relieves eye strain.

Robert J. White, M.D., made a decision on December 4, 1968, indicating that plaintiff was eligible for welfare benefits because of multiple physical problems (Tr. 171). At that time the physician indicated that plaintiff should be reexamined in three months to determine continuing eligibility. On March 27, 1969,

3/ American Medical Directory, 24th Edition, 1967.

Dr. White made a decision that plaintiff continued to be eligible for welfare benefits because of multiple physical problems (Tr. 165). Dr. White indicated that plaintiff appears to be well established on welfare, and with his physical limitations probably would not be able to earn as much as the welfare grant. Dr. White expressed the belief that plaintiff should be allowed to work within his limitations without penalizing his grant (Tr. 165). On August 26, 1969, Dr. White participated in a decision that plaintiff was still eligible for welfare benefits based on epilepsy with complications (Tr. 174). It was also indicated that plaintiff should be reexamined in one year to determine continuing eligibility.

The record includes a letter from the Veterans Administration informing plaintiff that he became entitled to $130 a month beginning October 20, 1970 (Tr. 126-127). This award was based on non-service connected disability. The payments were also based on an annual income of not over $500, and included his wife and two children as dependents (Tr. 126-127).

Plaintiff was born in 1936 and completed the eighth grade in school (Tr. 113, 85). According to the Report of Disability Interview dated January 26, 1971, plaintiff indicated that all his work had been light to heavy unskilled labor (Tr. 124). He had worked in a paper mill, lumber mill, on road construction, as a janitor, and as ski station operator (Tr. 124). He had testified that he worked at the Vermont State Hospital as an aide for a few months (Tr. 97). He quit that job because being on his feet constantly was too much for him. He entered the military service in November 1954 and served as a medical corpsman (Tr. 97). At some time during the last calendar quarter in 1970 plaintiff began assembling ski boot slings in his own home (Tr. 56). His average earnings for that year were somewhat in excess of $70 (Tr. 56). He did this work for two firms, Vermont Industrial Homeworks, and Vermont Ski Safety Equipment (Tr. 57-58). He no longer gets work from the Vermont Ski Safety Equipment Company because this firm went out of business (Tr. 58). On January 26, 1971 plaintiff indicated that he had been rejected for a job at the Vermont State Hospital because of his seizures (Tr. 125).

On January 26, 1971 plaintiff indicated that he was living with his wife and two children in a trailer (Tr. 123). Except for shaving he was taking care of his own personal needs. For recreation, he would play cards and checkers with his wife, and go fishing with his father in the summer. He lost his driving license because of the seizures. At the hearing which was held on October 17, 1972, plaintiff testified that he would help his wife clean up the trailer in the morning (Tr. 85). He also testified that his Veterans Administration benefits had been increased to $194 a month (Tr. 76). Plaintiff's wife also testified that he was receiving a $146 monthly benefit from the Department of Social Welfare, and that she was receiving $257 for herself and the children (Tr. 66). This amounted to a total income of $597 a month (Tr. 34).

Plaintiff's wife testified in his behalf at the hearing held October 17, 1972. She stated that when they lived in St. Albans he used to have nine or ten spells a day during the summer, and "they were hard" (Tr. 79). Since they left St. Albans he would have perhaps three or four a month, and she witnessed all of them (Tr. 79). He had urinary incontinence twice (Tr. 80). All of the seizures were violent, his body would become rigid and he would bite his tongue during all of the episodes (Tr. 80). He would fall but he never seemed to bruise himself (Tr. 80). One of these episodes occurred in front of their trailer when he lost his temper, had a spell, and fell to the ground (Tr. 81). One spell occurred at Kerbs Memorial Hospital at some time during the latter part of 1971 (Tr. 81). Currently, he was having about three or four seizures a month (Tr. 82). She believed that his first seizure occurred about in 1967 (Tr. 88). She testified that her husband takes his medication faithfully (Tr. 83).

Mrs. Mae Morse, plaintiff's aunt, submitted a letter to plaintiff's attorney concerning her knowledge of the plaintiff's epilepsy (Tr. 188-189). She had worked as an aide at Vermont State Hospital and worked on the wards where the epileptics were for weeks at a time. Therefore, she was acquainted with both types of seizures. When plaintiff started having seizures they were of the petit mal type. She saw him in his first grand mal seizure in 1969. In may of 1970 she had an opportunity to observe a "bad one." She had an opportunity to witness two seizures while she was on a visit to his mother's home. The second of the seizures occurred in August 1971 when they called the fire department for a respirator because they did not think that he would come out of it (Tr. 188-189).

Argument

To establish entitlement to disability insurance benefits or to a period of disability, plaintiff has the burden of proving that he had become disabled within the meaning of the Social Security Act. Robles v. Finch, 409 F.2d 84 (1 Cir. 1969), Ragan v. Finch, 435 F.2d 239 (6 Cir. 1970), cert. denied sub nom Ragan v. Richardson, 402 U.S. 986 (1971), Rhinehart v. Cohen, 439 F.2d 920 (9 Cir. 1971).

Plaintiff may be considered disabled within the meaning of the Social Security Act only if he is unable to perform any substantial gainful work because of a medical condition which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least 12 months. 42 U.S.C. 416(i)(1) and 423(d)(1). His impairment must be so severe as to prevent him from working not only in his usual occupation but in any other substantial gainful work considering his age, education, training and work experience. 42 U.S.C. 423(d)(2)(A). Evidence of a physical impairment is not enought to warrant an award of disability insurance benefits; plaintiff must also be precluded from engaging in any substantial gainful activity by reason of such impairment. Robles v. Finch, supra, Dupkunis v. Celebrezze, 323 F.2d 380 (3 Cir. 1963), Canaday v. Celebrezze, 367 F.2d 486 (4 Cir. 1966), King v. Gardner, 370 F.2d 652 (6 Cir. 1967).

In order for plaintiff to receive disability insurance benefits, it is imperative that he establish by credible evidence that he was disabled within the meaning of the Social Security Act prior to the date when he last met the insured status requirements of the Act. DeNato v. Finch, 436 F.2d 737 (3 Cir. 1971), Flack v. Cohen, 413 F.2d 278 (4 Cir. 1969), Ragan v. Finch, supra (6 Cir. 1970). Plaintiff last met the disability insured status requirements of the Act on June 30, 1971. In order for him to establish eligibility the evidence must demonstrate that his impairments were of a disabling level of severity by that date.

Whenever plaintiff is partially but not totally disabled by his impairments, he is not disabled within the meaning of the Social Security Act. Robinson v. Celebrezze, 326 F.2d 840 (5 Cir. 1964), Rodriguez v. Celebrezze, 349 F.2d 494 (1 Cir. 1965). Plaintiff's complaints cannot provide the basis of

entitlement when they are not supported by medical evidence. Peterson v. Gardner, 391 F.2d 208 (2 Cir. 1968), Floyd v. Finch, 441 F.2d 76 (6 Cir. 1971), Steimer v. Gardner, 395 F.2d 197 (9 Cir. 1968).

When plaintiff filed his application in 1970, he alleged that he became unable to work on September 15, 1966, at the age of 30 due to epilepsy. The administrative law judge found that plaintiff did not have an impairment, or combination of impairments, of sufficient severity to preclude him from engaging in substantial gainful activity for a period of not less than 12 months at any time on or before June 30, 1971, when he had the necessary disability insured status.

According to the medical evidence, plaintiff had: 1. Grand mal epilepsy; 2. Chronic emphysema; 3. Varicocele right testicle; 4. External hemorrhoids; 5. Chronic lumbosacral strain; 6. Chronic weakness of the left knee; 7. Dental caries; 8. Amblyopia of the left eye, idiopathic; and 9. Chronic sinusitis and chronic anxiety psychoneurosis. His principal impairment, and the only one that could have prevented him from being able to work, was the grand mal epilepsy. The evidence as to the frequency and type of his seizures is varied. If it could be established that he took his medication faithfully and still had three or four seizures a month, there would be no question as to his entitlement to the Social Security benefits he applied for.

Dr. Robert R. Engisch reported that plaintiff has a seizure disorder of long standing, and that he has grand mal seizures. This physician's medical report, which is dated October 23, 1972, indicates that he recently had an opportunity to witness one of the seizures. This seizure apparently occurred after June 30, 1971. In a subsequent report dated October 11, 1972, Dr. Engisch reported that plaintiff was disabled to a certain extent only. He was unable to drive a motor vehicle, operate dangerous machinery, and he had to avoid heights; and, for these reasons he would be unemployable in occupations with those requirements. He believed that plaintiff could work at any non-dangerous occupation.

Regulations No. 4 - Subpart P, Sections 11.02 and 11.03, at 20 C.F.R. folling §404.1539, the sections on epilepsy, require that the seizures be

substantiated by EEG, and that they occur with a specific frequency despite prescribed treatment. When plaintiff was seen in the Department of Neurology, Ambulatory Care Facility, DeGoesbriand Unit, Medical Center Hospital of Vermont on September 1, 1971, despite plaintiff's vehemence that he had been taking his medication, blood levels drawn on his last visit showed a Dilantin level of 0.6 mgs. percent and a Phenobarbital level of 0.9 mgs. percent, which is not therapeutic. When plaintiff was confronted with this information he stated that possibly he might miss an occasional dose of medication. The diagnostic impression was that he had a questionable seizure disorder in good control. It was recommended that he continue on his present prescribed medication. As to his vascular headaches the objective findings showed that the neurologic examination was within normal limits.

Except for the medical report submitted by Dr. W. Dale Hooper on September 23, 1970, and the most recent report submitted by Dr. Robert R. Engisch, the remainder of the medical reports referred to plaintiff's seizures as questionable epilepsy. Even Dr. Hooper reported that the neurological examination was grossly within normal limits except for diminished vision and hearing on the left. Despite the claims of numerous seizures occurring every month, the testimony fails to describe more than one episode which occurred in public, in a hospital, and one such episode which occurred in front of his trailer home. Even the plaintiff's aunt, who presented evidence of her familiarity with epilepsy, was able to describe only a few seizures, and her letter covered a period of a number of years.

Dr. Robert J. White, who participated in three decisions for the Department of Social Welfare establishing plaintiff's eligibility for welfare benefits on the basis of multiple physical problems, commented that plaintiff appeared to be well established on welfare, and with his physical limitations probably would not be able to earn as much as the welfare grant. This was probably why plaintiff had shown a lack of enthusiasm for the efforts of vocational rehabilitation.

When plaintiff was seen at the Veterans Administration Hospital on November 23, 1970, his examination was essentially within normal limits. Plaintiff cooperated poorly on sensation testing, but he appeared to be intact.

He refused to stay at the hospital and was discharged against medical advice. The record reveals that he was found to be entitled to disability benefits by the Veterans Administration based on non-service connected nervous condition, and residuals of a head injury or seizures. A back condition had not been found on his last examination. These payments were indicated to be based on an annual income of not over $500, and included his wife and two children as dependents.

Therefore, the administrative law judge could find no evidence of an impairment, or combination of impairments, of sufficient severity to preclude plaintiff from engaging in substantial gainful activity consistent with his past work experience, which began at any time on or before June 30, 1971, while he still had the necessary disability insured status. The requirement of the Regulations were not met. Furthermore, the frequency of seizures that was claimed had not been established.

That plaintiff was receiving benefit payments because of a disability found by the Veterans Administration is neither decisive nor controlling of the issue of disability presented here, and the courts have so ruled. Not only are the requirements and standards adopted by the Veterans Administration different from the standards embodied in the Social Security Act, as amended, and the Regulations promulgated thereunder, but the requirements and standards for a finding of disability by the Veterans Administration may vary within that agency itself, depending on the particular relief or payment sought by the individual applicant. The Secretary is entitled to make his own independent finding whether or not an individual is "disabled" within the meaning of the Social Security Act. Hicks v. Gardner, 393 F.2d 299 (4 Cir. 1968), Gee v. Celebrezze, 355 F.2d 849 (7 Cir. 1966), Piper v. Richardson, 315 F.Supp. 234 (W.D. Pa. 1970), Soto v. Secretary of HEW, 308 F. Supp. 603 (D. P.R. 1970).

That plaintiff was found to be entitled to benefits paid by the Department of Social Welfare is neither decisive nor controlling of the issue of disability. The medical decision establishing the plaintiff's eligibility to social welfare benefits indicates that factors other than his inability to work were considered.

The evidence of record, which included the results of medically acceptable clinical and laboratory diagnostic techniques, failed to establish

an impairment or combination of impairments of sufficient severity to prevent plaintiff from engaging in his customary work for a continuous period of not less than 12 months, at any time on or before June 30, 1971. He retained the physical capacity to engage in his former occupations or others similar to them. Accordingly, the decision of the administrative law judge was that plaintiff is not entitled to disability insurance benefits under Section 216(i) and 223 of the Social Security Act for which he filed his application. That decision became the final decision of the Secretary of Health, Education, and Welfare.

The Secretary is charged with the duty to weigh the evidence, to resolve material conflicts in the testimony and to determine the case accordingly. Richardson v. Perales, 402 U.S. 389 (1971), Moss v. Gardner, 411 F.2d 1195 (4 Cir. 1969), Staples v. Gardner, 357 F.2d 922 (5 Cir. 1966), Stumbo v. Gardner, 365 F.2d 275 (6 Cir. 1966), Celebrezze v. Bolas, 316 F.2d 498 (8 Cir. 1963), Rhinehart v. Finch, 438 F.2d 920 (9 Cir. 1971). The findings of the Secretary are conclusive if supported by substantial evidence and should be upheld even in those cases in which the reviewing court, had it heard the same evidence de novo, might have found otherwise. Robles v. Finch, supra, Labee v. Cohen, 408 F.2d 998 (5 Cir. 1969), Walters v. Gardner, 397 F.2d 89 (6 Cir. 1968).

Conclusion

There being substantial evidence of record to support the Secretary's decision that plaintiff failed to establish that he was disabled within the meaning of the Social Security Act at any time while he still retained an insured status under the Act for disability purposes and that therefore plaintiff was not entitled to disability benefits, it is respectfully submitted that defendant's motion for summary judgment be granted.

CASPAR W. WEINBERGER, Secretary of Health, Education, and Welfare

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March 27, 1974

CERTIFICATE OF SERVICE

I hereby certify this 27th day of March, 1974 that I served the foregoing MOTION FOR SUMMARY JUDGMENT and DEFENDANT'S MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT upon the plaintiff, by mailing copies of same with postage prepaid, to his attorneys, Daniel J. Lynch, Esq., Kissane & Meald, Esqs., 8 Congress Street, St. Albans, Vermont 05478, and James R. Flett, Esq., P.O. Box 589, St. Albans, Vermont 05478.

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IN THE

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

MARSHALL W. CLARK, JR.,

Appellant

v.

CASPAR WEINBERGER, SECRETARY
OF THE UNITED STATES DEPARTMENT
OF HEALTH, EDUCATION & WELFARE,

Appellee

CERTIFICATE OF SERVICE

I do hereby certify that on the 6th day of January, 1975, I made service of the BRIEF AND APPENDIX OF APPELLEE upon Marshall W. Clark, Jr., appellant, by mailing copies of same, postage prepaid, to Douglas L. Molde, Esq., Vermont Legal Aid, Inc., P.O. Box 589, 56 North Main Street, St. Albans, Vermont 05478, attorney of record for said appellant.

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